

**School-Based Mental Health Services (SBMH) Collaboration Partners**  
**Annual Verification of Recognition**

Community Mental Health Center: \_\_\_\_\_

School System(s): \_\_\_\_\_

**This document serves as a record of these organizations' intent to continue to be recognized as Partners in the School-Based Mental Health Collaboration for the upcoming year (beginning September 1), and as such, agree to comply with the fidelity of the SBMH Model, which includes the following minimum requirements:**

\_\_\_\_/\_\_\_\_ 1. We have participated in an initial orientation meeting with representatives from ALSDE and ADMH. This meeting was held on \_\_\_\_\_.

\_\_\_\_/\_\_\_\_ 2. We have formalized our agreement to participate in the SBMH Collaboration by the means of an MOA, contract, or other instrument which has been reviewed and will be in effect for the school year beginning September 1. A copy of this agreement is on file at ADMH and ALSDE.

\_\_\_\_/\_\_\_\_ 3. We agree to participate in data collection and reporting as required.

\_\_\_\_/\_\_\_\_ 4. We agree to use the standardized referral process and documentation.

\_\_\_\_/\_\_\_\_ 5. We agree to utilize a "Gatekeeper" at each school, who is preferably the School Counselor. Any exceptions to this practice will be discussed with ADMH/ALSDE staff and will be documented.

\_\_\_\_/\_\_\_\_ 6. We agree to conduct regular executive meetings between school leaders and mental health leaders to share billing/services provided and to solve problems/discuss difficult cases as required.

\_\_\_\_/\_\_\_\_ 7. The Community Mental Health Center agrees to provide one or more master's-level therapists with their own computer or other record-keeping capability to provide services at the school(s) served. The Local Education Agency agrees to provide a private space for counseling, and access to internet and telephone communications in support of the mental health therapist working at the school.

\_\_\_\_/\_\_\_\_ 8. We agree to maintain separation of school records and mental health records for legal and confidentiality purposes.

**By initialing each of the items above and signing below, we are verifying that our Local Education Agency and our Community Mental Health Center agree to work and plan together, and to cooperate in making every effort in good faith to meet the requirements listed above.**

\_\_\_\_\_  
*CMHC Representative Printed Name and Title*

x \_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*LEA Representative Printed Name and Title*

x \_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*